# Electronic Medical Record (EMR)

## 1 Role of the IT Department

The Information Technology (IT) department is responsible for the infrastructure, strategy and management of the EMR. The IT department hosts the Help Desk and provides customer service to providers utilizing LEO (LifeWays' EMR). The IT department sets up new users (including user names, passwords, and permissions), terminates users, and provides technical assistance. The IT department works with leadership to enhance the EMR and trouble shoot process issues; and pushes out upgrades and security protections to all LEO users as needed and required. The IT department will make every attempt to reduce interruptions to business operations and do required maintenance during off hours.

## 2 LEO Overview

The LifeWays Electronic Organizer (LEO) is the electronic medical record (EMR) used by LifeWays and the provider network. These terms (LEO and EMR) may be used interchangeably when referring to LifeWays' medical record system. LEO is an internet-based system.

## 3 Provider Access and Permissions

A LEO Administrator can add new staff and expire terminated or resigned staff. A LEO Administrator can also choose permissions for staff within LEO. Please contact your LEO Administrator for more information.

## 4 Provider LEO Training

New providers can request training from LifeWays by contacting the LifeWays Help Desk at 517.780.3367. The Information Systems Specialist will provide an overview to LEO and highlight general areas of use. Currently, LifeWays utilizes a Peer-to-Peer model for more specific training. Please contact your supervisor for LEO training related to your specific job.

Training classes are in development. Please refer to upcoming LEO Bulletins or Process Alerts or the LEO Website for updates on topics and registration information.

## 5 EMR Quality and Integrity Standards

There are a minimum of 54 standards necessary to determine an electronic medical record complete and accurate. Those standards are referenced below.

Attachment: 7-01.03-A LEO Quality and Integrity Standards for Electronic Medical Records

# 6 DATA REQUIREMENTS

SAMHSA's Synectics BH-TEDS (Behavioral Health-Treatment Episode Data Set) Award Agreement with MDHHS is an evolution of the Substance Use (Substance Use) Agreement to expand and include client-level mental health data in addition to the substance use data that's been collected in Michigan for 25 years. BHDDA leadership has decided that the national effort to combine these systems coupled with the advent of P.A. 500 and 501, provided an excellent opportunity to combine the substance abuse and mental health (SU-TEDS and QI Data) demographic files into a single system with a single coding schema.

Based upon a Time 1 - Time 2 architecture, BH-TEDS is used to measure the magnitude and direction of change between two points in time. This single data collection system for mental health and substance use treatment services utilizes the federal coding requires and additional Michigan-specific fields deemed necessary. The coding of these fields will now be the same, whether mental health or substance use. This has been repeatedly requested by CMHSPs for many years. Data is submitted to the Federal Government at the Time 2 point. The data is analyzed on a national, state, and local level.

Link: Copy of BH-TEDS Field Requirements

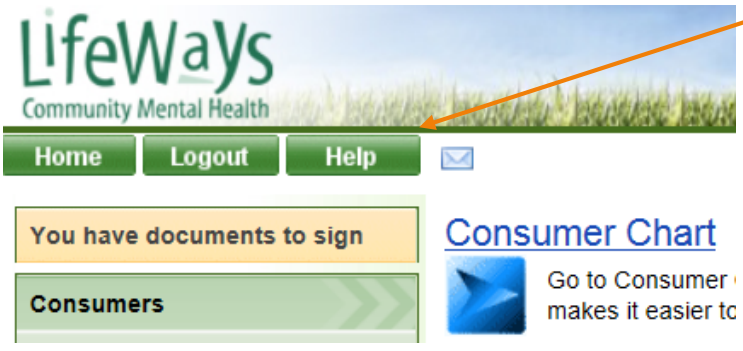
Link: Procedure 7-01.03 Electronic Medical Record.

# 7 HELP DESK

The LEO Help Desk is intended to provide technical assistance and troubleshooting of system errors for traditional business operations that currently exist within the EMR (LEO).

LifeWays Help Desk staff shall maintain high standards for timeliness of response and resolution, and maintain open communication with the user regarding attempts made to resolve the help desk ticket. The LEO Help Desk is not designed to field system enhancements or suggestions from end-users.

Several *How To Guides* are available for LEO users and may assist the user without the need of IT Support. These guides can be accessed when in LEO by clicking: Help

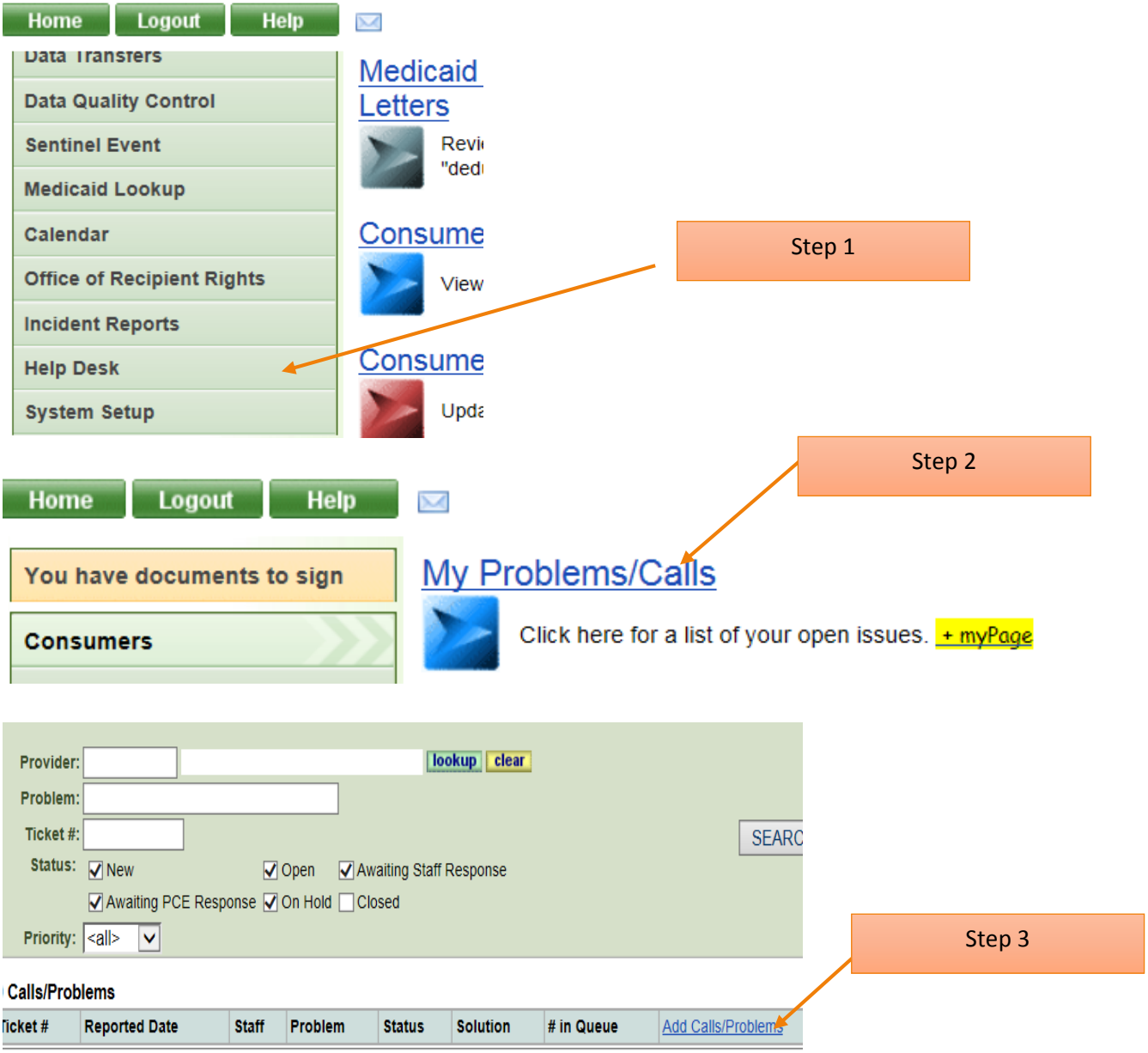



The LEO Help button at the top of the LEO Home page provides access to detailed instructions for several common issues related to LEO.

If the user is unable to self-resolve the issue, the user shall:

Submit a ***ticket*** through the Help Desk module within LEO for **non-urgent** issues.

The LEO Help Desk can be accessed while in LEO from the menu of items listed in the green box of the home page.




Step 4 is submitting the required information needed regarding your issue and clicking save. For additional detailed instructions for submitting a Help Desk ticket, please refer to the attachment below.

Contact the LEO Help Desk at ***517-780-3367*** (internal x2367) for **urgent** issues

Urgent is defined as something that impacts the provider's ability to move forward and complete their essential function.

LifeWays also maintains a LEO Help Desk Directory. If you have a specific subject matter that you need assistance with, please contact the following:

| SUBJECT MATTER | CONTACT PERSON |
|---|---|
| Contracts/Fee Schedules<br>Codes/Modifiers/Rates<br>Provider Records<br>COFRs<br>Single Case Agreements | Contract Manager<br>517.880.3353 |
| Incident Reports | Recipient Rights Administrative Assistant<br>517.789-1237 |
| Insurance Policies<br>Medicaid Look Up<br>Financial Information<br>Ability to Pay<br>Medicaid Application | Networks Benefits Specialist<br>517.789.2497 |
| Claims Processing<br>Remittance Advice | Claims Specialist<br>517.796.4586 |
| Password Resets<br>Staff Records/Assigning User IDs<br>Provider Administrator<br>User Access/Initial Menu View<br>Spell Check Dictionary Manager<br>Address Book Manager<br>Treatment Plans<br>Progress Notes<br>Medical Chart | Information Systems Specialist<br>517.780.3367 |
| Insurance Billing (PSU)<br>Consumer Billing/Account Balance<br>Injection Billing<br>Children's Waiver Billing | Billing Specialist<br>517.789.2481 |
| Encounters<br>QI Data Clean Up<br>Report Requests | Database Administrator<br>517.789.1268 |
| Consumer Authorizations<br>Self-Determination<br>Provider Assignments | Chief Operating Officer<br>517.796.4574 |
| Calendars (PSU)<br>Demographics (PSU) | Clinical Support Services Supervisor<br>517.796.4558 |
| Lab Results<br>BRMC Review | RN Supervisor<br>517.780.3360 |

# 8 LEO Bulletins

The LEO News Bulletin is published on the LifeWays website and emailed to the EMR List Serv. Bulletins will be archived on the LifeWays website for future reference and instruction. LEO News Bulletins are published monthly and contain valuable information regarding LEO and changes or upgrades to LEO. All providers are encouraged to sign up for LEO Bulletins as this is the main communication modality for changes or alerts regarding LEO.

To receive the LEO Bulletins, go to www.lifewayscmh.org and select: LifeWays e-Newsletter

LifeWays Electronic Organizer
Help Desk
LifeWays e-Newsletter
You will find this option near the bottom left of the home page. Once selected, you will be prompted for contact information and able to choose which newsletters you wish to receive.

# 9 System Enhancements & Recommendations

All recommendations for system enhancements shall be directed to LifeWays' Director of Quality Improvement & Information Technology via the System Change Request form. The process for change is illustrated in the attachment Change Control Process Flowchart.

Attachments: 07-01.03-C System Change Request form
07-01.03-B Change Control Process Flowchart

# 10 Security and Protection of PHI

All LifeWays staff and provider network shall comply with LifeWays policy and procedure for Uses and Disclosures of Protected Health Information.

Link: 7-02.06 Uses and Disclosures of Protected Health Information

# 11 Release of Information

A valid Release of Information form must be on file before any documents can be released. A release can be generated from LEO by going under Consents to Participate/Exchange Information. Once you have chosen the consumer:

Diagnosis
Consumer Calendar
PREVIOUS 1 2 3 4 5 6 7 8 9 ... NEXT
Add Consent to Exch. Info
Add Consent to Participate
Click *Add Consent to Exch. Info* to generate a new release.

Releases are time limited, so be sure to verify validity of the release if using one already on file. Refer to the Procedure below when releasing information.

Link: 6-03.01 Medical Record Release of Information

# 12 Meaningful Use

The goal of Meaningful Use is to improve patient care by "meaningfully using" an electronic medical record. The Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs provide financial incentives for the meaningful use of certified EHR technology to improve patient care. To receive an EHR incentive payment, providers have to show that they are meaningfully using their EHRs by meeting thresholds for a number of objectives. The Centers for Medicare and Medicaid Services (CMS) have established Meaningful Use objectives, which are specific, measurable ways in which an EHR can or must be used. The EHR Incentive Programs are phased in three stages with increasing requirements.

Stage 1: Data capture and sharing
Stage 2: Expand upon the Stage 1 criteria to encourage the use of health information technology and exchange for continuous quality improvement
Stage 3: Expand on Stage 2 with a focus on promoting improved outcomes in quality, safety, and Efficiency

Eligible professionals participate in the program on the calendar year, while eligible hospitals and Critical Access Hospitals participate according to the federal fiscal year.

Providers must attest to demonstrating meaningful use **every year** to receive an incentive and avoid a Medicare payment adjustment.

Before an eligible professional can meet MU requirements, they must acquire or have access to a CEHRT (Certified EHR Technology). EHR certification is conducted by an Office of the National Coordinator for Health Information Technology (ONC) Authorized Testing and Certification Body. PCE Systems, the vendor for LEO, has received the Certificate of Compliance for the 2014 Edition ONC Health IT Certification Program issued by ICSAlabs. If you wish to pursue Meaningful Use of the LEO system, please contact LifeWays' Information Technology Director.

# 13 CEHR Portal/Consumer Access to Medical Records

Providers should refer to LifeWays Consumer Access to Medical Records when a consumer wishes to have access to his or her medical record.

Link: 6-03.02 Consumer Access to Medical Records

LifeWays and PCE Systems would like to introduce a secure online portal for patients to access their own health information using the Internet. The Community Electronic Health Record (CEHR) is now available.

- **Features** include the ability to view diagnosis, track medications, vital signs, allergies, appointments, contact information, and other important components of their services.
- **Information** available is from the LEO electronic medical record that behavioral health care providers use to document services through the LifeWays network.
- **Benefits** of the patient portal is to inform the individual about their own health information and use this to work with their health care providers to manage their illness. The long-term goal is to use this portal as a way to interact with their health care provider and view treatment plan information.
- **Security** of the information is protected and encrypted using an SSL certificate, which meets the safeguards expected of Meaningful Use and HIPAA.

# 14 Business Continuity

Each provider is encouraged to have on hand at all times, paper forms in the event LEO is down during regular business hours. If an outage is anticipated (i.e. inclement weather), the minimum amount of information needed to continue services should be printed and available to staff. These items may include: schedules, last appointment notes, consumer contact information, etc. Each provider is responsible for the security of these records and should shred them once power is restored.

Link: 7-02.01 Business Continuity and Disaster Recovery

# 15 Transition to ICD-10 and DSM-5

<u>TRANSITION TO ICD-10:</u>
ICD-10 implementation has been delayed by one year, per recent legislation. The implementation is now effective 10/1/2015.

<u>Expected Future Changes:</u>

- We will continue with Phase 1 - B2B testing and collecting the ICD-10 diagnosis.
- We can still shift to Phase 2 on 10/1/14 - ICD-10 becomes the primary diagnosis and ICD-9 is housed in the system as backup and for encounter/claims/reporting next year.
- Phase 3 would begin next October - phase out of ICD-9 and only use it for claims with date of service 10/1/15.
- LifeWays is joining a PCE workgroup and continuing participation on the TSG state workgroup to follow and implement changes.

- Providers and LifeWays staff should continue to seek out clinical training opportunities for ICD-10.

TRANSITION TO DSM-5:

- It is important to note that there are no DSM-5 codes. Rather, there are new descriptions that need to be mapped to ICD. Our system is currently setup to accommodate a description for each code.
- Use of DSM is a clinical/professional decision, as billing is still done using ICD.
- The state workgroup is recommending a go-live date of 10/1/2015.

Expected Future Changes:

- The axial format would be removed from the LEO forms.
- The SAL (billing form on the document) will be updated to include diagnosis lookup so the clinician can specify the exact diagnosis addressed in that contact.
- Need to determine what replaces the Axis VI psychological and environmental factors. A DSM task force has recommended using a set of V codes and Z codes from the ICD.
- Need to determine what replaces the Axis V GAF score. A DSM task force is piloting the WHODAS (World Health Organization Disability Assessment).
- LifeWays is joining a PCE workgroup and continuing participation on the TSG (The Standards Group) state workgroup to follow and implement changes.
- Providers and LifeWays staff should continue to seek out clinical training opportunities for DSM-5.

**LEO Quality and Integrity Standards for Electronic Medical Records**

Effective: 8/1/2013
Purpose: The following table identifies the minimal standards necessary to determine an electronic medical record as complete and accurate.
Reference: LifeWays Operating Procedure: 07.01.03 Electronic Medical Record Management

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| 1 | AD | A staff assignment exists for each provider assignment. | There is at least 1 staff assignment under each provider assignment. |
| 2 | AD | Discharge pending approval is less than 14 days since author signature, or is absent. | Discharges present and pending UM approval are less than 14 days old. |
| 3 | AD | Open provider assignment has active authorization to serve the case. | There is a provider assignment for each authorized provider. Providers without active authorizations have been closed. |
| 4 | AD | Primary case holder is assigned for open case. | Open case has active primary case holder (staff) assigned. |
| 5 | AD | Primary provider is assigned for open case. | Open case has active primary provider assigned. |
| 6 | AS | If behavior treatment plan exists, BRMC case notes are present according to BTP review schedule. | Review the BTP for the indicated BRMC review schedule. The BRMC case review notes should be completed according to the specified BRMC review schedule. |
| 7 | AS | BRMC Case Review form is completed prior to discharge summary. | If discharge needs BRMC review, the BRMC case review form is less than the discharge form date. |
| 8 | AS | If child, CAFAS/PECFAS assessment has occurred in last three months. | If the consumer is age 7-17, a CAFAS score is present. If consumer is age 4-6, a PECFAS score is present. Score should be recently entered in the last 3 months. |
| 9 | AS | DD proxy measures have been completed in last 12 months. | If consumer has a DD disability designation, there is a DD proxy measure entered in the last 12 months. |
| 10 | AS | Assessment has occurred in last 12 months. | An intake or update assessment was completed within the last 12 months for open case. |
| 11 | AS | Health conditions are complete. | A selection is present for every health condition listed in the health & other conditions page. |
| 12 | AS | If consumer is authorized for a BTP, there is a BTP scanned into LEO | If consumer is authorized for H0032 BT there is a scanned BTP in the scanned document file. |
| 13 | AS | Psychiatric inpatient stays are managed through continued stay reviews and hospital discharge planning. | If psychiatric inpatient authorization is present, there is a continued stay review and hospital discharge from. |
| 14 | CR | Chart Notes are used appropriately for miscellaneous documents or chart warnings. | If a chart note is present in the record it is for miscellaneous purposes and not billable documentation or information that is applicably stored elsewhere. |
| 15 | CR | Consent to participate is present. | Consents to participate for all active providers are |

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| | | | completed electronically or scanned into the record. |
| 16 | CR | If consumer is enrolled in school (K-12), there is consent to release information to the school present. | Consents to exchange/release info to the child's school is completed electronically or scanned into the record, and is current. |
| 17 | CR | If consumer reports a primary care physician, consent to release information to the physician is present. | Consents to exchange/release info to the physician is completed electronically or scanned into the record, and is current. |
| 18 | CR | Diagnosis Axis are complete (Axis 1-5) | The full diagnosis table is complete, including Axis I, II, III, IV, and V. |
| 19 | CR | Advanced Directive status is collected and scanned into the chart is active. | Review the most recent consent to participate. If the consumer indicates that they have an active advanced directive, a copy is scanned into the consumer chart. |
| 20 | CR | Scanned documents are appropriately categorized and organized. | Review each scanned document that was entered during the current treatment plan and verify that the Document Type appropriately matches the content of the scanned image. The date of the document should match the date within the document, and not the date it was scanned. There should be no duplication of scanned documents. |
| 21 | CR | Care coordination/communication form is used and scanned into LEO in accordance with consents to release info (i.e. beginning services, medication changes, hospitalizations, discharges) | Care coordination is evident by a health care coordination form document in the record. |
| 22 | CR | If guardian is present there is guardianship papers are on file. | If a guardian is indicated in the Consumer Information, there are guardianship papers scanned into the consumer chart. |
| 23 | CR | No documents awaiting disclosure in the Medical Record queue. | The requested documents have been released externally and are not pending in the Document Disclosure Queue. |
| 24 | CR | No unsigned documents awaiting signature. | All documents are fully signed and not pending a staff signature. |
| 25 | CR | Consumer appointments are managed through updates to the appointment status. | Review consumer appointments and verify that the status of any past appointments has been changed from Scheduled to Kept, Cancelled or No-Show. |
| 26 | DQ | Address is complete and accurate | Complete and accurate address define by valid Street, City, St, Zip, Home Phone |
| 27 | DQ | Emergency contact information is present. | Emergency contact is provided or Section not applicable. |
| 28 | DQ | Primary guardian information is present. | Guardian is provided or Section not applicable. |
| 29 | DQ | Preferred pharmacy information is present. | Pharmacy is provided or Section not applicable. |
| 30 | DQ | Primary care physician information is present. | Physician is provided or Section not applicable. |
| 31 | DQ | Absence of critical data errors. | Consumer chart is free from all data quality errors. |

**LEO Quality and Integrity Standards for Electronic Medical Records**

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| 32 | FI | A current self-pay (financial determination) is complete, verified by LifeWays. | Self-pay is present and includes the consumer's signature that is obtained digitally or is scanned in as an attachment to the policy. Supporting financial documentation is scanned in as an attachment to the policy. |
| 33 | FI | Insurance policies are verified. | All insurance policies for the case are Verified and not in Awaiting Verification status. |
| 34 | FI | Medicaid deductible policy is present if the consumer is on a deductible. | If the consumer is on a Medicaid deductible, there is a Deductible policy entered in the insurance policy area and it is not expired until the deductible no longer applies. |
| 36 | IR | Incident Reports are routed for signature and reviewed/signed in a timely matter. | Search IR module for all incident reports for the consumer and verify that they have been fully reviewed by all Reviewers as indicated by a Review Date next to each reviewer. (The Review Date should not be null.) |
| 37 | MC | Medication consents are present and include consumer and medical staff signature for all current medications. | Review the most recent Medication Review to determine the medications that are active, then review the Signed Medication Consents in the Medical Chart to determine if there's a signed consent for each active medication. |
| 38 | MC | AIMS worksheet is completed quarterly for psychotropic medications. | Review CMH Medications to determine if Psychotropic medications have been prescribed and evaluate if AIMS testing has been completed every three months since the effective date of the prescription. |
| 39 | MC | Allergies/adverse reactions have been completed in last 12 months. | Adverse reaction/allergies have been recorded within the last 12 months. If no allergies, this is accurately recorded as NKDA-No Know Drug Allergies as the "Drug/Allergen". |
| 40 | MC | Dispense notes are present for injectable medications. | If consumer is prescribed an Injectable Medication, dispense notes are present to record the dispensing at the frequency noted within the prescription. |
| 41 | MC | Lab results are scanned or electronically transmitted; results are reviewed by ordering physician. | If consumer has a Lab Order in LEO, there is a corresponding Lab Result that has been reviewed by the ordering physician. |
| 42 | MC | CMH medications are present and current, and align with the most recent medication review note. | Review last medication review and cross-walk with the CMH prescribed medications for accuracy and completeness. |
| 43 | MC | No lab results awaiting review. | There are no lab results for the case that are Pending Review in the medical chart. |
| 44 | MC | Non-CMH medications are present and current (consumer self reports). | Review last medication review and cross-walk with the non-CMH prescribed medications for accuracy and completeness. |
| 45 | MC | Initial Psychiatric Evaluation is present. | A psychiatric evaluation is present. |
| 46 | MC | No verbal orders awaiting review. | There are no verbal orders awaiting the physician's approval for the case. |
| 47 | MC | Vital signs have been completed in last 12 | If authorization for medication review or psychiatric |

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| | | months for consumers receiving Psychiatric services. | evaluation is present, there are vital signs recorded within the last 12 months. |
| 48 | PG | Progress notes are present for all active providers. | Review authorized providers and cross-reference with the progress note module. A progress note should be present for all active/authorized providers. The progress notes should be entered electronically if a e-format for the note is available; otherwise, a scanned progress note is accepted. |
| 49 | TP | Residential quality of life assessment was completed by residential staff prior to PCP meeting. | If consumer has specialized residential services (verify in demos and the treatment plan shell/header), there is a residential quality of life assessment included in the treatment plan and it was completed by the residential staff before the date of the PCP meeting. |
| 50 | TP | Consumer signatures are obtained digitally or scanned in as an Attachment to the Treatment plan. | Consumer's signature can be found within the Treatment Plan print or as a scanned document within the Attachments. |
| 51 | TP | Copy of treatment plan is provided to consumer. | Treatment plan shell (header) displays the date and method in which the copy of plan was provided. |
| 52 | TP | Notice of Hearing Rights is signed by consumer and scanned in as an Attachment to the Treatment plan (including subsequent Addendums). | Signed paper notice is scanned is as an Attachment to the treatment plan or plan addendum. |
| 53 | TP | Treatment plan formal review has occurred quarterly since treatment plan effective date. | A formal review was completed every 3 months, using the electronic form, since the treatment plan effective date. |
| 54 | TP | Treatment plan is fully signed by provider staff. | Treatment plan is entered electronically (not scanned) and is not pending staff signature. |

[End]

## SUD and MH and Situational BH-TEDS Fields

| Field ID | | | Admission | | | Discharge/Update | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SUD | Mental Health | | SUD | Mental Health | | | | | |
| T1 | T2 | Field Name | A | M | M w/Int Tx* | D | E | E (MH w/Int Tx)* | U (MH) | U (MH w/Int Tx)* | F (Federal) or S (State) Field | Federal Data Set |
| A001 | DU001 | Client Transaction Type | A | M | M | D | E | E | U | U | F | MDS |
| A002 | DU002 | System Transaction Type | A | M | M | D | E | E | U | U | F | SDS |
| A003 | DU003 | Payer ID | A | M | M | D | E | E | U | U | S | |
| A004 | DU004 | State Provider Identifier | A | M | M | D | E | E | U | U | F | MDS |
| A005 | DU005 | Unique PIHP Person Identifier | A | M | M | D | E | E | U | U | F | MDS |
| A006 | DU006 | Social Security Number | A | M | M | D | E | E | U | U | S | |
| A007 | DU007 | Medicaid ID | Report if individual has known identifier whether or not currently enrolled and/or eligible | | | | | | | | S | |
| A008 | DU008 | MIChild ID | | | | | | | | | S | |
| A009 | DU009 | Medicare ID | | | | | | | | | S | |
| A010 | DU010 | SDA/SSI/SSDI Enrollment | A | M | M | D | E | E | U | U | S | |
| A011 | DU011 | Service Start Date | A | M | M | D | E | E | U | U | F | MDS |
| A012 | DU012 | Service Start Date Time of Day | A | M | M | D | E | E | U | U | S | |
| A013 | | Time to Treatment | A | M | M | | | | | | F | SuDS |
| A014 | | Referral Source | A | M | M | | | | | | F | MDS |
| A015 | | Detailed Criminal Justice Referral | A | M | M | | | | | | F | SuDS |
| A016 | DU013 | Type of Treatment Service Setting | A | M | M | D | E | E | U | U | F | MDS |
| A017 | DU014 | Codependent/Collateral Person Served | A | M (always 2-Client) | M (always 2-Client) | D | E | E | U | U | F | MDS |
| | DU015 | Date of Service Update/End | | | | D | E | E | U | U | F | MDS |
| | DU016 | Service Update/End Time of Day | | | | D | E | E | U | U | S | |
| | DU017 | Reason for Service Update/End | | | | D | E | E | U | U | F | MDS |
| A018 | DU018 | ID/DD Designation | A | M | M | D | E | E | U | U | S | |
| A019 | DU019 | MI/SED Designation | A | M | M | D | E | E | U | U | S | |
| A020 | DU020 | Detailed SMI/SED Status | A | M | M | D | E | E | U | U | F | MHA |
| A021 | | Prior Treatment Episodes | A | M | M | | | | | | F | MDS |
| A022 | | Date of Birth | A | M | M | | | | | | F | MDS |
| A023 | | Gender | A | M | M | | | | | | F | MDS |
| A024 | | Pregnant at Service Start Date | A | M | M | | | | | | F | SuDS |
| A025 | | County of Residence | A | M | M | | | | | | S | |

| Coding Keys |
|---|
| MH & SUD NOM |
| MH NOM |
| SUD NOM |
| Federal Unduplicated Client Count Calculations |
| |
| **S**ystem **D**ata **S**et |
| **M**inimum **D**ata **Set** |
| **Su**plemental **D**ata **S**et |
| **M**ental **H**ealth Specific **A**dmission Set |

*M w/Int Tx = M record for individual receiving integrated MH/SA treatment funded w/MH Dollars Only

| Field ID | | | Admission | | | Discharge/Update | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SUD | Mental Health | | SUD | Mental Health | | | | | |
| T1 | T2 | Field Name | A | M | M w/Int Tx* | D | E | E (MH w/Int Tx)* | U (MH) | U (MH w/Int Tx)* | F (Federal) or S (State) Field | Federal Data Set |
| A026 | | Race | A | M | M | | | | | | F | MDS |
| A027 | | Hispanic or Latino Ethnicity | A | M | M | | | | | | F | MDS |
| A028 | DU021 | Mainstream Special Education Status | A | M | M | D | E | E | U | U | S | |
| A029 | DU022 | Education | A | M | M | D | E | E | U | U | F | MDS |
| A030 | DU023 | School Attendance Status | A | M | M | D | E | E | U | U | F | MHA |
| A031 | | Marital Status | A | M | M | | | | | | F | SuDS |
| A032 | | Veteran Status | A | M | M | | | | | | F | SuDS |
| A033 | DU024 | Employment Status | A | M | M | D | E | E | U | U | F | MDS |
| A034 | DU025 | Detailed 'Not in Competitive, Integrated Labor Force' | A | M | M | D | E | E | U | U | F | SuDS |
| A035 | DU026 | Minimum Wage | A | M | M | D | E | E | U | U | S | |
| A036 | DU027 | Total Annual Income | A | M | M | D | E | E | U | U | S | |
| A037 | DU028 | Number of Dependents | A | M | M | D | E | E | U | U | S | |
| A038 | DU029 | Primary Substance Use Problem | A | M (usually 01-None) | M | D | E (usually 01-None) | E | U (usually 01-None) | U | F | MDS |
| A039 | | Primary Route of Administration | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A040 | DU030 | Primary Frequency of Use | A | M (usually 96-N/A) | M | D | E (usually 96-N/A) | E | U (usually 96-N/A) | U | F | MDS |
| A041 | | Primary Age at First Use | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A042 | DU031 | Secondary Substance Use Problem | A | M (usually 01-None) | M | D | E (usually 01-None) | E | U (usually 01-None) | U | F | MDS |
| A043 | | Secondary Route of Administration | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A044 | DU032 | Secondary Frequency of Use | A | M (usually 96-N/A) | M | D | E (usually 96-N/A) | E | U (usually 96-N/A) | U | F | MDS |
| A045 | | Secondary Age at First Use | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A046 | DU033 | Tertiary Substance Use Problem | A | M (usually 01-None) | M | D | E (usually 01-None) | E | U (usually 01-None) | U | F | MDS |

*M w/Int Tx = M record for individual receiving integrated MH/SA treatment funded w/MH Dollars Only

| Field ID | | | Admission | | | Discharge/Update | | | | | F (Federal) or S (State) Field | Federal Data Set |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | SUD | Mental Health | | SUD | Mental Health | | | | | |
| T1 | T2 | Field Name | A | M | M w/Int Tx* | D | E | E (MH w/Int Tx)* | U (MH) | U (MH w/Int Tx)* | | |
| A047 | | Tertiary Route of Administration | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A048 | DU034 | Tertiary Frequency of Use | A | M (usually 96-N/A) | M | D | E (usually 96-N/A) | E | U (usually 96-N/A) | U | F | MDS |
| A049 | | Tertiary Age at First Use | A | M (usually 96-N/A) | M | | | | | | F | MDS |
| A050 | | Medication-assisted Opioid Therapy | A | M (6-N/A) | M | | | | | | F | MDS |
| A051 | | Integrated Substance Use and Mental Health Treatment | A | M | M | | | | | | F | SuDS |
| A052 | DU035 | Living Arrangements | A | M | M | D | E | E | U | U | F | SuDS |
| A053 | DU036 | Detailed Residential Care Living Arrangement | A | M | M | D | E | E | U | U | S | |
| A054 | DU037 | Arrests in Past 30 Days | A | M | M | D | E | E | U | U | F | SuDS |
| A055 | DU038 | Corrections Related Status | A | M | M | D | E | E | U | U | S | |
| A056 | DU039 | Attendance at Self-help Groups in Past 30 Days | A | M (usually 96-N/A) | M | D | E (usually 96-N/A) | E | U (usually 96-N/A) | U | F | SuDS |
| A057 | DU040 | Diagnostic Code Set Identifier | A | M | M | D | E | E | U | U | F | SuDS |
| A058 | | Substance Use Diagnosis | A | M | M | | | | | | F | SuDS |
| A059 | DU041 | MH Diagnostic Code One | A | M | M | D | E | E | U | U | F | MHA |
| A060 | DU042 | MH Diagnostic Code Two | A | M | M | D | E | E | U | U | F | MHA |
| A061 | DU043 | MH Diagnostic Code Three | A | M | M | D | E | E | U | U | F | MHA |
| A062 | | Legal Status at Admission to State Hospital | A (96-N/A) | M | M | | | | | | F | MHA |
| A063 | DU044 | Error ID | Enter Error ID when applicable; otherwise, blanks | | | | | | | | S | |
| A065 | DU045 | Filler | A | M | M | D | E | E | U | U | S | |

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## 7.01.03 ELECTRONIC MEDICAL RECORD (EMR) MANAGEMENT

PURPOSE: The purpose of this operating procedure is to establish a management process for the electronic medical record that defines access and permissions, system integrity and record completeness standards, training and technical assistance efforts, system change control process, and communication plans.

Management of the EMR requires decision-making, planning and quality improvement throughout its life cycle. The EMR is a mission-critical function that supports the provision of care across the entire provider network system. As a result, procedures must be in place to support the integrity and accuracy of the information and components in order to achieve the highest effectiveness from the product. It is also imperative that users of the product follow strict access, confidentiality and security practices to provide for acceptable use and security of the protected health information maintained by the system.

SYSTEM COMPATIBILITY

The LEO system is hosted, developed and maintained by PCE Systems. The LEO applicable is available in three environments: 1) production, 2) training, and 3) development. The production environment is the live setting that users use for electronic health record documentation. The training environment is a duplicate of production to use for training purposes; changes within training will not harm the production system. The development environment is used to create and test new system changes before they are moved to production.

Internet Explorer: The LEO application is programmed to be compatible with Internet Explorer (IE). There are specific functions and forms that are not fully operable unless used in Internet Explorer. Therefore, the agency requires that Internet Explorer is used as the web browser to run the LEO system. The most recent version of Internet Explorer should always be used, as PCE Systems works diligently to maintain compatibility with the newest IE release.

ACCESS AND PERMISSIONS

Expected Use: LifeWays staff and contracted service providers are expected to fully implement the LEO system within their workflow to document services rendered. Staff of programs or providers that are authorized to serve a LifeWays consumer is expected to document care using all appropriate modules and forms that have been made available and within their scope of care. This requirement is to ensure complete and accurate service documentation and facilitate effective care coordination amongst mutually serving program and providers within the LifeWays CMH system. There are no exclusions to the requirement to use the LEO system unless a user can demonstrate that it creates a significant hardship and this has been reported to and approved by the Director of Quality Improvement & Technology Services.

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User Setup: The agency is responsible for the oversight and establishment of access levels and permissions within the EMR system. The LifeWays Information Systems Specialist is responsible for user setup, granting permissions and ongoing monitoring to ensure security and privacy is upheld. User setup shall be a centralized role within the agency that is managed by the IT team.

Provider Administrator: LifeWays may choose to delegate the setup and management of provider staff users to a designated and trained Provider Administrator at each provider agency. This is considered a privileged function; high ethical standards and security practices must be applied within this role. These permissions can be removed at any time by the agency. The Provider Administrator must follow the user setup manual provided by LifeWays. The Provider Administrator is expected to strictly adhere to LifeWays guidelines regarding creation and management of functional access and privileges for users. LifeWays shall monitor the Provider Administrators user setup audit trails and the integrity of their managed users to ensure security and privacy is upheld within user access levels. LifeWays reserves the right to modify user setup at any time if it is determined to be inappropriate. Non-compliance with the expectations as a Provider Administrator will result in revoke privileges and possible corrective action.

All system users are responsible for maintaining secure practices, including:

1. Privacy of **passwords**;
2. Maintaining **physical control** of the equipment that is used to access the EMR; and
3. Following the **minimum-necessary rule** for accessing and disclosing protected health information.

Secure Passwords: Passwords security is critical to the protection of information in the EMR. Users have a primary role to minimize the risk of improper disclosure by using the following required secure password practices.

1. Keep password secure and confidential to all others.
2. Create strong passwords using alpha, numeric and special characters.
3. Change the password completely when prompted by the system or if security has been compromised.
4. Lock the computer workstation when stepping away from your device every time. This can be done by using Ctrl-Alt-Delete and then selecting “Lock this Computer.”
5. Do not share password with others
6. Do not write down the password.
7. Do not allow others to log in as you.
8. Do not allow other people to watch you key your password in.
9. Do not save your password in your internet browser.

Passwords are set to expire every 90 days in the EMR. If you forgot your password, you may use the link “Forgot My Password” on the login screen to reset it and obtain a temporary password. If you have been locked out due to many unsuccessful attempts, you will need to contact the IT help desk (517-780-3367) to obtain a reset.

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Physical Controls: Users are responsible for maintaining the physical security of their workstation that is used to access the EMR and protected health information. This includes immediately locking the device when not in use, closing doors when away from the office where the device is located, placing devices out of site when traveling (e.g. truck of car), password-protecting the device for user authentication, and being aware of the immediate surroundings and risks.

Minimum-Necessary Rule: Users are created with very specific access to areas in the EMR based on their position and function. It is expected that the user access only the minimum information that is necessary to complete their job function. The actions carried out by users in the EMR are logged and recorded. This includes all attempts to read, write and delete data. LifeWays reserves the right to review the audit trails to determine if the access level is necessary and appropriate. Audit trail reports are available to LifeWays System Administrators on the IT team.

The agency retains the right to terminate any user access at any time.

ACCESS TO CASE RECORDS

Users are granted access to case records in LEO based on their affiliation with a service location. LifeWays or the designated Provider Administrator is responsible for assigning the user to a location and grating functional access. Location assignments must be done with great care and caution. Users shall not be assigned to locations in which they are not employed. Once assigned to a specific location by LifeWays or the Provider Administrator, the user will have access to the consumer records that are also assigned to that location. Case records within the assigned location must be accessed on a need to know basis. Simply having access to the file does not grant the user rights to review protected health information.

Terminated Access: It is expected that users complete a discharge summary immediately when it is known that their organization/program will no longer serve the case; a discharge summary will close out the access level. The IT team may request a discharge summary from the provider to properly close from the case. LifeWays reserves the right to conduct an administrative closure of agencies or users to remove access to a case record when there is a period of inactivity. The purpose is to minimize case access to only users that are authorized for service delivery and are activity serving the case.

Once the case is closed, the provider and assigned staff will have limited view-only access to the case through LEO for a period of 90 days. The 90-day window after case closure is intended to provide the user with limited access to the case in order to complete final claims submission and clinical documentation activities. After the 90-day period, the system will automatically restrict access to the record and the user is forbidden from accessing the consumer's electronic medical record.

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INTEGRITY AND COMPLETENESS OF INFORMATION

EMR Standards: Professionals accessing the EMR shall consistently follow the standards established by the agency to achieve and maintain a high level of integrity and completeness of information within the EMR. The agency has established a detailed set of **Quality and Integrity Standards for Electronic Medical Records** (Attachment 1). Conformance to these standards is expected by all users.

Use of Electronic Forms: LifeWays has created electronic forms within the EMR for primary chart documents. These forms must be completed electronically within LEO and are no longer offered on paper. It is expected that users fully utilize the electronic forms as appropriate to their scope and practice. A scanned document of a paper form is unacceptable if an electronic form has been made available.

The following is a list of the standardized clinical forms that are required for providers and programs of LifeWays:

- Access Screening
- Crisis Intervention
- Clubhouse Progress Note, Weekly
- Death Report
- Discharge Summary
- Financial Determination
- Group Progress Note
- Incident Report
- Injection Dispense Note
- Intake/Update Assessment
- Integrated Health Assessment
- Medication Delivery Progress Note
- Medication Review
- Pre-Planning
- Progress Note
- Psychiatric Evaluation
- Residential Quality of Life Assessment (for services providing in a residential setting)
- Supported Employment Progress Note
- Treatment Plan & Crisis Plan
- Treatment Plan Addendum
- Treatment Plan Formal Review

The following is a list of the optional electronic forms that are available within LEO to providers/programs of LifeWays. It is understood that programs may utilize this form or their own

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forms until a standard consent is created for the entire CMH network. At that time, the LEO consents will become mandatory.

- Consent to Exchange/Release Information
- Consent to Participate in Services

Scanned Documents: If a particular electronic form does not exist in the system, the user may scan in their version of the form to complete the electronic record. It is expected that scanned documents are consistently uploaded using the appropriate category type to enhance the organization of these images. Each scanned document page shall include the consumer's name and case number. Additionally, the date of the scanned document shall match the date of the scanned image for historical archiving.

Timeliness of Signed Documents: Users shall recognize the importance of completing clinical documentation soon after the contact with the consumer. Unsigned documents negatively impact billing, encounter reporting, timeliness reporting, and other areas of performance. As a result, LifeWays has adopted a timeliness standard for clinical forms in LEO to be completed within 3 business days from the date of service. Therefore, clinical documents must be fully executed – completed and signed – within 3 business days of the date of service. The first exception to this rule are crisis interventions, which must be completed within 24 hours from the time of disposition. The second exception to this rule are progress monitoring notes for specialized outpatient services – specifically, RN, RD, BT, and OT services – which must be completed within 5 business days from the date of service.

Document Deletion: The agency maintains a position that the documentation in the EMR system must be of high integrity. Therefore, documents entered in the LEO system are considered part of a permanent record and shall not be deleted. The only exception to this standard is documentation that is done in error (e.g. wrong chart, duplication). If a document has been entered in error, the user shall report this to their Supervisor for deletion. If the Supervisor does not have permissions to delete that specific type of document the request for deletion shall be reported to the LifeWays IT Help Desk by the user's supervisor with a written request to delete (using the Help Desk module to enter a ticket), which signifies the supervisor's approval of the document deletion. A LifeWays System Administrator (IT Staff) retains all rights to deleting documentation and will only execute this task when written confirmation from the requestor's supervisor has been received and it is determined to be done in error. If there are identified patterns at the user level regarding the volume and frequency of requests to delete documents, the agency reserves the right to remove the user's access to the EMR and request a training plan.

LifeWays shall evaluate compliance with these standards through periodic desk audits. The auditing results shall be used for corrective action and continuous quality improvement in an effort to support the integrity and proper utilization of the EMR.

TRAINING AND TECHNICAL ASSISTANCE

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Training: The agency maintains the responsibility to provide training and education to users to support competency, system integrity, security and compliance with the EMR standards. Training can be conducted through various methods, including: live instruction, e-learning modules, written instructions with screen layouts, videos with screencasting, etc. The trainer of the content shall be a subject matter expert. LifeWays may user a peer or skilled training within a provider or program to transfer knowledge. Training needs shall be evaluated through an annual survey process. Requests for training can be made through the IT help desk at any time. The IT team will coordinate a training to occur with the subject matter experts.

LifeWays may request a corrective action plan if, after adequate training and technical assistance has been provided to the user, non-compliance with EMR standards and expectations remains. The Quality Improvement & Technology Division shall engage the Contract Management Team in any corrective action processes related to the EMR standards and expectations.

Resources: The agency shall supply various learning materials, such as written instructions, how-to guides, FAQs, tutorials or other forms of educational content that can be made readily accessible and utilized by the end-user when technical assistance or troubleshooting is needed.

Help Desk: If the user is unable to self-resolve the issue, the user shall contact the LEO Help Desk by calling 517-780-3367 (internal x2367) or submitting a ticket through the Help Desk module within LEO. The LEO Help Desk is intended to provide technical assistance and troubleshooting of system errors for traditional business operations that currently exist within the EMR. The agency shall maintain high standards for timeliness of response and resolution, and maintain open communication with the user regarding attempts made to resolve the help desk ticket. The LEO Help Desk is not designed to field system enhancements or suggestions from end-users.

Enhancements or suggestions for system improvement and modification shall follow a separate and formal change control process.

SYSTEM CHANGE CONTROL PROCESS

It is expected that the system will evolve and changes will be necessary as areas for improvement are identified. The agency shall maintain an organized process for receiving and implementing system enhancements. The following change control process will be followed for EMR system changes:

| Phase | Description of Systems Development Life Cycle |
|---|---|
| 1. Initiation | Begins when a user identifies a need or an opportunity. The *System Change Request* form is completed. System analysis is conducted to validate the request. |
| 2. System Concept | Determines feasibility. Defines the scope or boundary of the concept. |

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|---|---|---|
| | Development | Determines impact, expected outcomes and measures for success. The *System Change Request* form is updated. |
| 3. | Design and Planning | The functions and operations are described in detail, including screen layouts, business rules, process diagrams, and other documentation. A prototype is created for the Development system. The *System Change Request* form is updated to reflect the implementation and communication plan. |
| 4. | Prototype Testing and Pilot | The prototype is loaded in the Development system for user testing and training. Additional modifications are requested from the developer as necessary to meet the expected outcomes. Input is received from primary end users. |
| 5. | Implementation and Training | The tested prototype is deployed to the Production system on a scheduled date. End users receive communication and instructional material from the agency for training purposes. |
| 6. | Sustainment | The change is re-evaluated for success based on the previously defined outcome measures. Input is received from primary end users to determine success. |

COMMUNICATION

The agency shall follow the change control process for system enhancements in order to effectively communicate with system users. Changes are communicated primarily through the LEO News Bulletin, which is published on the LifeWays website and emailed to the EMR List Serv (managed in Constant Contact). The Bulletin shall describe the purpose, description of the change and effective date. The agency shall release the Bulletin as official notice of a scheduled change. Changes will usually occur on the first day of the following month. Primary users shall be provided with the opportunity to test the change in the Development system and provide input before it is in the Production system. Bulletins will be archived on the LifeWays website for future reference and instruction. The agency will use the LifeWays Provider Meeting as a mechanism to communicate critical changes to the system, provide training and seek input.

| **REFERENCES** |
|---|
| U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) |
| U.S. Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009 |
| LifeWays Operating Procedures |
| 07-01.01 Data Validation and Management |

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07-01.02 Reporting Services
07-02.02 Information Access and Systems Security
07-02.06 Use and Disclosures of Protected Health Information
07-02.07 Mobile and Portable Systems and Security
07-03.02 Information Systems Service Desk

Forms

LEO Systems Change Request

Attachments

LEO Quality and Integrity Standards for Electronic Medical Records
System Change Control Process Flowchart
System Change Request form

LEO Instructional Materials

How-To Guides

How to Update Consumer Demographics
How to Add an Admission, Provider Assignment, Staff Assignment, and Discharge a Consumer
How to Add an Initial Intake
How to Add Consumer Notices
How to Change a Signed Document
How to Early Terminate an Authorization
How to Navigate the Consumer Chart
How to Add / Request Authorizations
How to Update the Intake
How to Update a Consumer's Diagnosis
How to Add Consumer Allergies / Adverse Reactions
How to Add DD Proxy Measures
How to Complete a Service Activity Log
How to Complete a CAFAS/PECFAS Assessment
How to Use Discussions
How to Use Electronic Labs

Flow Charts

Access Center Screening Process Flow
Access Center Intake Process Flow
Utilization Management Process Flow
PSU / Support Staff Process Flow
Provider Clinical Process Flow
Provider Claims Process Flow

FAQ

User Manuals
Login and Navigation User Manual
Access Screenings, Crisis Interventions, Intake Assessments User Manual
Treatment Plans User Manual
Service Activity Logs User Manual

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|---|
| Provider Claims User Manual<br>Provider Management User Manual<br>Calendar User Manual<br>Case Load User Manual<br>Sentinel Events User Manual<br>Death Report User Manual<br>Court Orders User Manual<br>Integrated Health Assessment User Manual<br>Consent to Exchange Information User Manual<br>Progress Notes User Manual<br>Medication Review Process<br>Incident Report Manual |
| **HISTORY** |
| Effective 03/01/2014 Rev. 7/14, 9/14 |

**LEO Quality and Integrity Standards for Electronic Medical Records**

Effective: 8/1/2013
Purpose: The following table identifies the minimal standards necessary to determine an electronic medical record as complete and accurate.
Reference: LifeWays Operating Procedure: 07.01.03 Electronic Medical Record Management

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| 1 | AD | A staff assignment exists for each provider assignment. | There is at least 1 staff assignment under each provider assignment. |
| 2 | AD | Discharge pending approval is less than 14 days since author signature, or is absent. | Discharges present and pending UM approval are less than 14 days old. |
| 3 | AD | Open provider assignment has active authorization to serve the case. | There is a provider assignment for each authorized provider. Providers without active authorizations have been closed. |
| 4 | AD | Primary case holder is assigned for open case. | Open case has active primary case holder (staff) assigned. |
| 5 | AD | Primary provider is assigned for open case. | Open case has active primary provider assigned. |
| 6 | AS | If behavior treatment plan exists, BRMC case notes are present according to BTP review schedule. | Review the BTP for the indicated BRMC review schedule. The BRMC case review notes should be completed according to the specified BRMC review schedule. |
| 7 | AS | BRMC Case Review form is completed prior to discharge summary. | If discharge needs BRMC review, the BRMC case review form is less than the discharge form date. |
| 8 | AS | If child, CAFAS/PECFAS assessment has occurred in last three months. | If the consumer is age 7-17, a CAFAS score is present. If consumer is age 4-6, a PECFAS score is present. Score should be recently entered in the last 3 months. |
| 9 | AS | DD proxy measures have been completed in last 12 months. | If consumer has a DD disability designation, there is a DD proxy measure entered in the last 12 months. |
| 10 | AS | Assessment has occurred in last 12 months. | An intake or update assessment was completed within the last 12 months for open case. |
| 11 | AS | Health conditions are complete. | A selection is present for every health condition listed in the health & other conditions page. |
| 12 | AS | If consumer is authorized for a BTP, there is a BTP scanned into LEO | If consumer is authorized for H0032 BT there is a scanned BTP in the scanned document file. |
| 13 | AS | Psychiatric inpatient stays are managed through continued stay reviews and hospital discharge planning. | If psychiatric inpatient authorization is present, there is a continued stay review and hospital discharge from. |
| 14 | CR | Chart Notes are used appropriately for miscellaneous documents or chart warnings. | If a chart note is present in the record it is for miscellaneous purposes and not billable documentation or information that is applicably stored elsewhere. |
| 15 | CR | Consent to participate is present. | Consents to participate for all active providers are |

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| | | | completed electronically or scanned into the record. |
| 16 | CR | If consumer is enrolled in school (K-12), there is consent to release information to the school present. | Consents to exchange/release info to the child's school is completed electronically or scanned into the record, and is current. |
| 17 | CR | If consumer reports a primary care physician, consent to release information to the physician is present. | Consents to exchange/release info to the physician is completed electronically or scanned into the record, and is current. |
| 18 | CR | Diagnosis Axis are complete (Axis 1-5) | The full diagnosis table is complete, including Axis I, II, III, IV, and V. |
| 19 | CR | Advanced Directive status is collected and scanned into the chart is active. | Review the most recent consent to participate. If the consumer indicates that they have an active advanced directive, a copy is scanned into the consumer chart. |
| 20 | CR | Scanned documents are appropriately categorized and organized. | Review each scanned document that was entered during the current treatment plan and verify that the Document Type appropriately matches the content of the scanned image. The date of the document should match the date within the document, and not the date it was scanned. There should be no duplication of scanned documents. |
| 21 | CR | Care coordination/communication form is used and scanned into LEO in accordance with consents to release info (i.e. beginning services, medication changes, hospitalizations, discharges) | Care coordination is evident by a health care coordination form document in the record. |
| 22 | CR | If guardian is present there is guardianship papers are on file. | If a guardian is indicated in the Consumer Information, there are guardianship papers scanned into the consumer chart. |
| 23 | CR | No documents awaiting disclosure in the Medical Record queue. | The requested documents have been released externally and are not pending in the Document Disclosure Queue. |
| 24 | CR | No unsigned documents awaiting signature. | All documents are fully signed and not pending a staff signature. |
| 25 | CR | Consumer appointments are managed through updates to the appointment status. | Review consumer appointments and verify that the status of any past appointments has been changed from Scheduled to Kept, Cancelled or No-Show. |
| 26 | DQ | Address is complete and accurate | Complete and accurate address define by valid Street, City, St, Zip, Home Phone |
| 27 | DQ | Emergency contact information is present. | Emergency contact is provided or Section not applicable. |
| 28 | DQ | Primary guardian information is present. | Guardian is provided or Section not applicable. |
| 29 | DQ | Preferred pharmacy information is present. | Pharmacy is provided or Section not applicable. |
| 30 | DQ | Primary care physician information is present. | Physician is provided or Section not applicable. |
| 31 | DQ | Absence of critical data errors. | Consumer chart is free from all data quality errors. |

**LEO Quality and Integrity Standards for Electronic Medical Records**

| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| 32 | FI | A current self-pay (financial determination) is complete, verified by LifeWays. | Self-pay is present and includes the consumer's signature that is obtained digitally or is scanned in as an attachment to the policy. Supporting financial documentation is scanned in as an attachment to the policy. |
| 33 | FI | Insurance policies are verified. | All insurance policies for the case are Verified and not in Awaiting Verification status. |
| 34 | FI | Medicaid deductible policy is present if the consumer is on a deductible. | If the consumer is on a Medicaid deductible, there is a Deductible policy entered in the insurance policy area and it is not expired until the deductible no longer applies. |
| 36 | IR | Incident Reports are routed for signature and reviewed/signed in a timely matter. | Search IR module for all incident reports for the consumer and verify that they have been fully reviewed by all Reviewers as indicated by a Review Date next to each reviewer. (The Review Date should not be null.) |
| 37 | MC | Medication consents are present and include consumer and medical staff signature for all current medications. | Review the most recent Medication Review to determine the medications that are active, then review the Signed Medication Consents in the Medical Chart to determine if there's a signed consent for each active medication. |
| 38 | MC | AIMS worksheet is completed quarterly for psychotropic medications. | Review CMH Medications to determine if Psychotropic medications have been prescribed and evaluate if AIMS testing has been completed every three months since the effective date of the prescription. |
| 39 | MC | Allergies/adverse reactions have been completed in last 12 months. | Adverse reaction/allergies have been recorded within the last 12 months. If no allergies, this is accurately recorded as NKDA-No Know Drug Allergies as the "Drug/Allergen". |
| 40 | MC | Dispense notes are present for injectable medications. | If consumer is prescribed an Injectable Medication, dispense notes are present to record the dispensing at the frequency noted within the prescription. |
| 41 | MC | Lab results are scanned or electronically transmitted; results are reviewed by ordering physician. | If consumer has a Lab Order in LEO, there is a corresponding Lab Result that has been reviewed by the ordering physician. |
| 42 | MC | CMH medications are present and current, and align with the most recent medication review note. | Review last medication review and cross-walk with the CMH prescribed medications for accuracy and completeness. |
| 43 | MC | No lab results awaiting review. | There are no lab results for the case that are Pending Review in the medical chart. |
| 44 | MC | Non-CMH medications are present and current (consumer self reports). | Review last medication review and cross-walk with the non-CMH prescribed medications for accuracy and completeness. |
| 45 | MC | Initial Psychiatric Evaluation is present. | A psychiatric evaluation is present. |
| 46 | MC | No verbal orders awaiting review. | There are no verbal orders awaiting the physician's approval for the case. |
| 47 | MC | Vital signs have been completed in last 12 | If authorization for medication review or psychiatric |

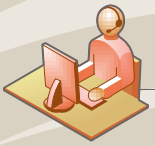
| Item # | Category | Indicator | Evaluation Criteria |
|---|---|---|---|
| | | months for consumers receiving Psychiatric services. | evaluation is present, there are vital signs recorded within the last 12 months. |
| 48 | PG | Progress notes are present for all active providers. | Review authorized providers and cross-reference with the progress note module. A progress note should be present for all active/authorized providers. The progress notes should be entered electronically if a e-format for the note is available; otherwise, a scanned progress note is accepted. |
| 49 | TP | Residential quality of life assessment was completed by residential staff prior to PCP meeting. | If consumer has specialized residential services (verify in demos and the treatment plan shell/header), there is a residential quality of life assessment included in the treatment plan and it was completed by the residential staff before the date of the PCP meeting. |
| 50 | TP | Consumer signatures are obtained digitally or scanned in as an Attachment to the Treatment plan. | Consumer's signature can be found within the Treatment Plan print or as a scanned document within the Attachments. |
| 51 | TP | Copy of treatment plan is provided to consumer. | Treatment plan shell (header) displays the date and method in which the copy of plan was provided. |
| 52 | TP | Notice of Hearing Rights is signed by consumer and scanned in as an Attachment to the Treatment plan (including subsequent Addendums). | Signed paper notice is scanned is as an Attachment to the treatment plan or plan addendum. |
| 53 | TP | Treatment plan formal review has occurred quarterly since treatment plan effective date. | A formal review was completed every 3 months, using the electronic form, since the treatment plan effective date. |
| 54 | TP | Treatment plan is fully signed by provider staff. | Treatment plan is entered electronically (not scanned) and is not pending staff signature. |

[End]

# Electronic Medical Record Management System Change Control Process Flowchart

August 1, 2013

**1-Initiation**
-Define need
-Initiate system concept
-Define scope
-Prioritize



LifeWays System Enhancement?

No

Refer to Help Desk / Close

Yes

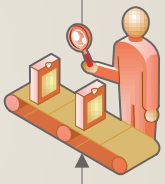
No

**2-System Concept Development**
-Assess value and feasibility
-Recommend solution
-Define impact and expected outcomes
-Define measure for success
-Schedule according to priority list

Approve Enhancement?

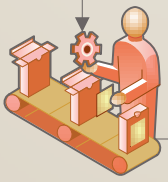
Yes

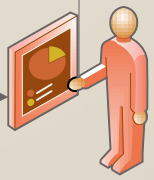
**3-Design & Planning**
-Define change
-Define purpose
-Develop screen layout
-Develop process diagram
-Develop instructional manual and business rules
-Develop screencasting video or training



**6-Sustainment**
-Re-evaluate change
-Seek input from primary users
-Subsequent revisions

**4-Prototype Testing & Pilot**
-Development system test
-Input from primary users
-Subsequent revisions





**5-Implementation & Training**
-Deployed to Production system
-Communicated through News Bulletin
-Training materials published on website

# LEO System Change Request Form

**Requested By:**

**Email:**

**Date of Request:**

## *Identify Need & Initiate System Concept Development*

A. Describe the problem:

B. Describe the recommended solution or concept:

C. Define the scope or boundaries of the concept:

D. Describe the impact, expected outcomes, and how success will be measured:

E. Does this enhancement fit into the LifeWays mission and values? ☐ Yes ☐ No

F. Does this enhancement fit into the LifeWays strategic plan? ☐ Yes ☐ No

G. Does a lack of the enhancement inhibit quality service delivery to the consumer? ☐ Yes ☐ No

H. Does the opportunity impact: *(Mark all that apply)*

☐ Quality ☐ Productivity ☐ Safety ☐ Customer Satisfaction

I. Rating:

1. Rate the **severity (S)** of the problem (The seriousness of the problem or condition (non-conformance) as it relates to the consumers and/or the internal/external customers.)

| | | | |
|---|---|---|---|
| ☐ | 5 | Very High | Safety issue which poses potential harm to consumer and/or internal/external customers |
| ☐ | 4 | High | Ethical or quality issues that impacts service to internal/external customer(s) |
| ☐ | 3 | Moderate | Probably has a noticeable effect on internal/external customer(s) satisfaction |
| ☐ | 2 | Low | Slight chance of the internal/external customer(s) noticing the effect |
| ☐ | 1 | Minor | Unlikely internal/external customer(s) noticing the effect |

2. Rate the **occurrence (O)** of the problem (the number of times the problem or condition (non-conformance) occurs during the defined process cycle, within the scope of the element.

| | | | |
|---|---|---|---|
| ☒ | 5 | Very High | 80% or more of the time |
| ☐ | 4 | High | 60% - 79% |
| ☐ | 3 | Moderate | 40% - 59% |
| ☐ | 2 | Low | 20% - 39% |
| ☐ | 1 | Minor | 0% - 19% |

3. Determine the **number (N)** of consumers and/or customers affected (The number of consumers and/or internal/external customers affected by the problem or condition (non-conformance) during a defined period of time, within the scope of the element).

| | | | |
|---|---|---|---|
| ☐ | 5 | Very High | 80% or more of consumers |
| ☐ | 4 | High | 60% - 79% |
| ☐ | 3 | Moderate | 40% - 59% |
| ☐ | 2 | Low | 20% - 39% |
| ☐ | 1 | Minor | 0% - 19% |

**LEO System Change Request Form**

**Priority Ranking Score:** **PRS = (S) x (O) x (N)**

## *Design & Planning*

Description of design and planned change:

Purpose of the change:

Attachments:

☐ Screen layout
☐ Process diagram
☐ Instruction manual with business rules
☐ Screencasting video

## *Prototype Testing & Pilot*

Development System-Effective Date: _____

Summary of input from testing and subsequent modifications:

## *Implementation & Training*

Production System-Effective Date: _____

☐ Included in News Bulletin
☐ Training materials posted on website

## *Sustainment*

Planned Evaluation Date:

Measures used to determine success:

Results of evaluation:

References: LifeWays Operating Procedure 07.01.03 Electronic Medical Record Management

# LEO System Change Request Form

**Requested By:**

**Email:**

**Date of Request:**

## *Identify Need & Initiate System Concept Development*

A. Describe the problem:

B. Describe the recommended solution or concept:

C. Define the scope or boundaries of the concept:

D. Describe the impact, expected outcomes, and how success will be measured:

E. Does this enhancement fit into the LifeWays mission and values? ☐ Yes ☐ No

F. Does this enhancement fit into the LifeWays strategic plan? ☐ Yes ☐ No

G. Does a lack of the enhancement inhibit quality service delivery to the consumer? ☐ Yes ☐ No

H. Does the opportunity impact: *(Mark all that apply)*

☐ Quality ☐ Productivity ☐ Safety ☐ Customer Satisfaction

I. Rating:

1. Rate the **severity (S)** of the problem (The seriousness of the problem or condition (non-conformance) as it relates to the consumers and/or the internal/external customers.)

| | | | |
|---|---|---|---|
| ☐ | 5 | Very High | Safety issue which poses potential harm to consumer and/or internal/external customers |
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| ☐ | 3 | Moderate | Probably has a noticeable effect on internal/external customer(s) satisfaction |
| ☐ | 2 | Low | Slight chance of the internal/external customer(s) noticing the effect |
| ☐ | 1 | Minor | Unlikely internal/external customer(s) noticing the effect |

2. Rate the **occurrence (O)** of the problem (the number of times the problem or condition (non-conformance) occurs during the defined process cycle, within the scope of the element.

| | | | |
|---|---|---|---|
| ☒ | 5 | Very High | 80% or more of the time |
| ☐ | 4 | High | 60% - 79% |
| ☐ | 3 | Moderate | 40% - 59% |
| ☐ | 2 | Low | 20% - 39% |
| ☐ | 1 | Minor | 0% - 19% |

3. Determine the **number (N)** of consumers and/or customers affected (The number of consumers and/or internal/external customers affected by the problem or condition (non-conformance) during a defined period of time, within the scope of the element).

| | | | |
|---|---|---|---|
| ☐ | 5 | Very High | 80% or more of consumers |
| ☐ | 4 | High | 60% - 79% |
| ☐ | 3 | Moderate | 40% - 59% |
| ☐ | 2 | Low | 20% - 39% |
| ☐ | 1 | Minor | 0% - 19% |

**LEO System Change Request Form**

**Priority Ranking Score:** **PRS = (S) x (O) x (N)**

## *Design & Planning*

Description of design and planned change:

Purpose of the change:

Attachments:

☐ Screen layout
☐ Process diagram
☐ Instruction manual with business rules
☐ Screencasting video

## *Prototype Testing & Pilot*

Development System-Effective Date: _____

Summary of input from testing and subsequent modifications:

## *Implementation & Training*

Production System-Effective Date: _____

☐ Included in News Bulletin
☐ Training materials posted on website

## *Sustainment*

Planned Evaluation Date:

Measures used to determine success:

Results of evaluation:

References: LifeWays Operating Procedure 07.01.03 Electronic Medical Record Management

| SECTION | | GOVERNING POLICY | |
|---|---|---|---|
| 7.00 Information Technology | | 02 Information Security and Risk Management | |
| **SUBJECT:** | | | |
| 06 Uses and Disclosures of Protected Health Information | | | |
| **EFFECTIVE DATE**: | 03/10/2010 | **REVIEWED/REVISED:** | |

**07-02.06 USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

PURPOSE: The purpose of this operating procedure is to outline the process for the proper disposal of paper, records, documents, and data that convey confidential medical information in accordance with HIPAA regulations, state laws and internal confidentiality policies.

OBJECTIVE

Title II of HIPAA (Health Insurance Portability and Accountability Act), known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. The Administration Simplification provisions also address the security and privacy of health data.

DEFINITIONS

A. Legally Protected Information:

1) Patient care records (including mental health records), medical records, referral forms, research records, practitioner notes, pharmaceutical prescriptions and any document or material that contains consumer identification (name, address, phone number) and diagnostic information.

2) Peer review, quality management, utilization review, risk management, credentialing files.

3) Regulatory reports, incident reports, unusual occurrence reports, abuse reports.

B. Internal Confidential Information

1) Proprietary information

2) Financial records and reports

3) Business transaction records

C. Protected Health Information

1) Names

2) All geographical identifiers smaller than a state, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census: the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000

3) Dates (other than year) directly related to an individual

| SECTION | | GOVERNING POLICY | |
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| 7.00 Information Technology | | 02 Information Security and Risk Management | |
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| **EFFECTIVE DATE**: | 03/10/2010 | **REVIEWED/REVISED:** | |

4) Phone numbers
5) Fax numbers
6) Email addresses
7) Social Security numbers
8) Medical record numbers
9) Health insurance beneficiary numbers
10) Account numbers
11) Certificate/license numbers
12) Vehicle identifiers and serial numbers, including license plate numbers;
13) Device identifiers and serial numbers;
14) Web Uniform Resource Locators (URLs)
15) Internet Protocol (IP) address numbers
16) Biometric identifiers, including finger, retinal and voice prints
17) Full face photographic images and any comparable images
18) Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data

POLICY

It is the policy of LifeWays to protect the privacy and confidentiality of all consumer medical records and information contained in the medical records, including the consumer's Protected Health Information (PHI), in accordance with applicable state and federal laws and ethical standards. LifeWays prohibits persons not authorized by law to obtain access to or copies of a consumer's PHI and medical records. LifeWays will provide a consumer access to, and the right to obtain copy of, his or her PHI in the medical record as long as it is maintained in the medical record and in accordance with this procedure.

Medical records of LifeWays consumers which are maintained by LifeWays and its provider network, recorded in any form, including data recorded on paper, scanned images, in a computer database or any other medium constitute the property of LifeWays. LifeWays prohibits the removal of any original medical records from LifeWays premises or electronic medical records, unless the records are ordered by a court of law or other government authority to be produced in the original form.

PROCEDURE

| SECTION | | GOVERNING POLICY | |
|---|---|---|---|
| 7.00 Information Technology | | 02 Information Security and Risk Management | |
| **SUBJECT:** | | | |
| 06 Uses and Disclosures of Protected Health Information | | | |
| **EFFECTIVE DATE**: | 03/10/2010 | **REVIEWED/REVISED:** | |

1) A LifeWays department that generates confidential information with regard to consumers is responsible to maintain the materials in a confidential manner.

2) At the appropriate time (in accordance with Michigan's Records Retention law) the department in which the materials are generated and stored may elect to shred the materials utilizing one of LifeWays' standard document shredders.

3) Certain departments may generate highly sensitive documents in large volumes, necessitating purchased contract services for material destruction. (i.e., materials coming out of document retention).

4) Documents stored in file boxes shall be appropriately labeled with Contents type, and date designated for destruction, based on the Records Retention Law.

| **REFERENCES** |
|---|
| U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) |
| LifeWays Privacy Notice |
| LifeWays Policy |
| 01-06 Record Retention and Disposal |
| 06-04 Medical Record Management |
| LifeWays Operating Procedures |
| 07-05.06 Electronic Mail Guidelines and Requirements |
| 06-04.01 Medical Record Release of Information |
| 06-04.02 Provider Access to Closed Records |
| 06-04.03 Retention & Disposal of Medical Records |
| 06-04.04 Transfer of Consumer Files |
| 06-04.05 Denial of Consumer Requests |

| **HISTORY** | |
|---|---|
| Effective 03/10/2014 | Rev. |

| CHAPTER | | GOVERNING POLICY | |
|---|---|---|---|
| 6.00 Consumer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 01 Medical Record Release of Information | | | |
| **EFFECTIVE DATE**: | 09/30/1997 | **REVIEWED/REVISED:** | 04/12/2012 |

**6-03.01 MEDICAL RECORD RELEASE OF INFORMATION**

PURPOSE: To release information for the purpose of coordination of care, to receive SSI benefits, legal purposes, etc.

All requests for Medical Release of Information received by LifeWays are forwarded to Customer Services. The CSS (Customer Services Specialist) reviews each release. Releases typically fall into one of the categories below:

- Open Consumer (file located at provider site).
- Valid Request for Medical Records - Closed file (file located in Customer Services).
- Invalid request for Medical Records – Closed File.
- No Record of Person in Computer System.

Following is the process for each category:

Open Consumer (File Located at Provider Site)

Upon checking in the computer, if it is an open case, the request is forwarded to the consumer's primary provider. The consumer's name, company-agency requesting the information and the primary provider is logged in the "Release of Information Requests" binder before the release is forwarded.

Valid Request for Medical Records – Closed File

Requests should be processed within five (5) working days from date stamped by LifeWays.

Copying Charge - if the request is to assist in coordination of care, such as a hospital, social security or doctor, there is no charge. Otherwise the charge for copying is .20 per page. Payment must be received before the information can be given out. Send a letter to the person/agency requesting the information (Attachment A) and file in the folder entitled "Payment Required." Send a copy of the letter to the Finance Team. The "Payment Required" folder may be purged every ninety (90) days.

Information which may be copied from the medical record includes:

- Initial Intake/Protocol - found under the Clinical Assess. (Non Medical) tab.
- Treatment Plan (during the past year) - found under the Clinical Treatment tab.
- Treatment Plan (Individual Plan of Service).
- Annual Psychiatric Assessments (up to the last two) - found under the Progress Notes Incidents tab/Treatment section (Physician Unit files only). It is usually indicated by a colored 3M tab (Initial is purple, annual is yellow, and all others are red).
- Medication Reviews (during the past year) - found under the Progress Notes Incidents tab. It is usually indicated by a red 3M tab.

| CHAPTER | | GOVERNING POLICY | |
|---|---|---|---|
| 6.00 Consumer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 01 Medical Record Release of Information | | | |
| **EFFECTIVE DATE**: | 09/30/1997 | **REVIEWED/REVISED:** | 04/12/2012 |

Additional information must be approved by the Clinical Director.

The information is copied and then mailed with the following - A copy of the Consent to Release Information form (Attachment C), the copied records, and a cover letter (Attachment A).

Complete Form #1023, the Documentation of Released Information (Attachment B) and staple to the original request and a copy of the cover letter. File in the section entitled "Consent and Authorizations" of the medical record.

The consumer's name, company-agency requesting the information and the date the information is logged in the "Release of Information Requests" binder.

Invalid Request for Medical Records - Closed File

Invalid request are those not meeting the criteria set in the Michigan Mental Health Code, 330.1748, permitting releases as referenced in this section.

Return the request with a cover letter (Attachment D) to the sender with a copy of Form #1009, Consent for the Mutual Release of Confidential Information (Attachment C). Once valid release is received the release of information request will be processed.

No Record of Person In Computer System

Return the request with a Cover Letter to the Sender (Attachment E) indicating there is no record of the person. Log the information on the "No Record of Person Log" in Release of Information Request binder. It is not necessary to retain a copy of the request or letter.

Subpoenas for Information in Closed Records

All subpoenas are forwarded to the Recipient Rights Team Leader and reviewed on a case-by-case basis. Following is the process, which usually occurs.

Within two (2) working days, the Recipient Rights Team Leader will determine validity and notify Customer Services. If approved, the subpoena copy will be forwarded to Customer Services indicating it is a valid subpoena and to process. Per the instructions of the Recipient Rights Manager, Customer Services shall copy the information and forward to the Clinical Director for approval.

If approved, a copy of the subpoena, the copied records and a cover letter (Attachment A) is mailed to the person/agency. The Released Information form is completed and stapled to the original subpoena with a copy of the cover letter. The information is filed in the "Consent and Authorizations" section of the medical record.

| **CHAPTER** | | **GOVERNING POLICY** | |
|---|---|---|---|
| 6.00 Consumer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 01 Medical Record Release of Information | | | |
| **EFFECTIVE DATE**: | 09/30/1997 | **REVIEWED/REVISED:** | 04/12/2012 |

Note - There is usually a check sent with the subpoena. Determine the copying charge amount and if it is less than the check amount, subtract the check amount from the copying charge to determine their balance, and send the person/agency a letter stating the amount owed.

| **REFERENCES** |
|---|
| Forms<br>Found Release Notice<br>Released Medical Records Worksheet – Form #1023<br>Consent for the Mutual Release of Confidential Information – Form #1009<br>Incorrect Language Letter<br>Letter: No Record of Person |
| **HISTORY** |
| Effective 09/30/1997 — Rev. 3/01, 6/02, 2/03, 6/07, 9/07, 8/08, 1/09, 9/09 |

| **CHAPTER** | | **GOVERNING POLICY** | |
|---|---|---|---|
| 6.00 Customer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 02 Consumer Access to Medical Records | | | |
| **EFFECTIVE DATE**: | 12/01/2013 | **REVIEWED/REVISED:** | 11/01/2014 |

## 6-03.02 CONSUMER ACCESS TO MEDICAL RECORDS

PURPOSE: To establish a mechanism for the Consumer, parent, or legally authorized representative to request access for review or photocopying of the Consumers' health and/or financial information.

DEFINITIONS

"Consumer" refers to the person who is the subject of the Protected Health Information.

"Designated Record Set" means:

1. a group of records (including any item, collection or grouping of information that includes Protected Health Information maintained, collected, used or disseminated by LifeWays) that is:
    a. The medical records and billing records about an Individual maintained by or for LifeWays
    b. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for LifeWays; or
    c. Used, in whole or in part, by or for LifeWays to make decisions about Individuals.

"Individual" refers to the person who is the requestor of the protected health information and may include any one of the following: the Consumer (if the Consumer is over the age of 18 years, legally emancipated or there are other circumstances under Michigan law which allow a minor patient to access his/her own record), the Consumer's parent (if the Consumer is under the age of 18 years), the Consumer's appointed guardian (regardless of Consumer's age), or the Consumer's personal representative.

"Protected Patient Health and Financial Information" (PHI) means any information, whether verbal or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearing house; and relates to the past, present or future physical or mental health or condition of an Individual; the provision of the health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual.

PROCEDURE

An Individual shall be able to make a written request for inspection and/or copies of a Consumer's PHI and financial information. This request is completed through the "Application For Access to Recipient Case Record Information" form. Such access shall be granted for inspection or requested copies by LifeWays, unless the request is denied by a licensed health care professional. There are two types of denials: non-reviewable or reviewable, as documented in this policy.

| **CHAPTER** | | **GOVERNING POLICY** | |
|---|---|---|---|
| 6.00 Customer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 02 Consumer Access to Medical Records | | | |
| **EFFECTIVE DATE**: | 12/01/2013 | **REVIEWED/REVISED:** | 11/01/2014 |

LifeWays contracted providers are responsible for establishing a process for dealing with Consumer access to health information in compliance with this policy. LifeWays contracted providers are prohibited to release any documentation not authored by their paid staff. LifeWays Community Mental Health, as the owner of the record in its entirety has authority to access and release any and all pieces of record with exception as defined by the HIPAA and LifeWays Procedure. Items not privy for release shall not be included in the LifeWays electronic medical record (LEO), i.e., psychotherapy notes.

1. Requests for Access and Timely Action. LifeWays shall permit an individual to request (in writing) access to inspect and/or to obtain a copy of an consumer's PHI that is maintained in a designated record set.
    a. Upon receipt of a request, LifeWays shall make reasonable efforts to verify the identity of the person making the request and determine whether such person is an Individual. LifeWays shall not inquire as to the purpose of any request.
    b. LifeWays shall make its best efforts to act, whether granting or denying the request, by providing the Individual with a written response, within fifteen (15) calendar days after receipt of the written request for access or inspection.
    c. Notwithstanding the foregoing, in the event that LifeWays is unable to provide a response to a request within thirty (30) calendar days after receipt of the request, LifeWays shall provide a written statement to the Individual of the reasons for any delay and the date by which LifeWays will complete its response to the request, which shall not be later than thirty (30) calendar days after delivery of the notice of delay. In the event that the PHI requested does not exist, or cannot be found and produced within sixty (60) calendar days after receipt of the initial request, LifeWays shall inform the Individual that the PHI cannot be produced.
    d. If the requested PHI is not maintained or accessible to LifeWays on-site, LifeWays shall either produce the PHI or provide a written denial no later than sixty (60) calendar days from the receipt of the initial request. If LifeWays is unable to take such action within sixty (60) calendar days of the receipt of the request, then LifeWays shall provide a written statement to the Individual of the reasons for any delay and the date by which LifeWays will complete its response to the request, which shall not be later than thirty (30) calendar days after delivery of the notice of delay.
    e. Only one extension of time for action will be allowed for each request made by an Individual.

2. Access of Protected Health Information Provided. If a LifeWays entity provides an Individual with access, in whole or in part, to PHI, the following will be required:
    a. The individual must request access to inspect and/or copy PHI in writing.
    b. LifeWays must provide the access of PHI requested by Individuals, including inspection or obtaining a copy, or both, in designated record sets. If the same PHI requested is

maintained in more than one designed record set or at more than one location, LifeWays will only provide the requested PHI once in response to a written request for access.

c. LifeWays must provide the designated record sets in hard copy or electronic format as requested by the individual. If electronic format is required, LifeWays shall load requested information on an encrypted, password protected flash drive.

d. LifeWays must provide the Individual with access to the PHI in the form or format requested by the Individual, if it is readily producible in such form or format. If the information requested is not readily producible in the requested format, then LifeWays and the Individual will agree on an alternative format. If, for good reason, LifeWays cannot agree to any format requested by the Individual, LifeWays shall provide the PHI in the format LifeWays reasonably believes is most like that requested by the Individual, and which is practical under the circumstances.

e. LifeWays may provide the Individual with a summary of the PHI requested, in lieu of providing access to the PHI, or may provide an explanation of the PHI to which access has been provided, if the Individual agrees in advance to such a summary or explanation.

f. Except as otherwise provided in Section 1, LifeWays must provide the access as requested by the Individual, within thirty (30) days after receipt of the request, including arranging with the Individual for a convenient time and place to inspect or obtain a copy of the PHI, or mailing the copy of the PHI at the Individual's request. LifeWays may discuss the scope, format, and other aspects of the request for access with the individual as necessary to facilitate the timely provision of access.

3. Access of PHI Denied. If LifeWays denies access, in whole or in part, to PHI, LifeWays must comply with the following requirements:

   a. LifeWays must, to the extent possible, give the individual access to any other PHI requested, after excluding the PHI that is being denied;

   b. LifeWays must provide written denial (See Attachment A) to the individual within thirty (30) calendar days following receipt of the request. The denial must be in plain language and contain the following:
      (i) The basis for the denial;
      (ii) If applicable, a statement of the individual's review rights, including a description of how the individual may exercise such review rights; and
      (iii) A description of how the individual may complain to LifeWays or to the Secretary of Health and Human Services. The description must include the name, or title, and telephone number of the contact person;

   c. If LifeWays does not maintain the PHI that is the subject of the individual's request for access and LifeWays knows where the requested information is maintained, must inform the individual where to direct the request for access.

   d. If the individual has requested a review of a denial, LifeWays will designate a licensed health care professional, who was not directly involved in the denial, to review the decision to deny

access. LifeWays must *promptly* (not longer than thirty (30) calendar days) refer a request for review to such designated reviewing official. The designated reviewing official must determine, within a reasonable period of time (not longer than thirty (30) calendar days), whether or not to deny the access requested. LifeWays must *promptly* (not longer than thirty (30) calendar days) provide written notice to the individual of the determination of the designated reviewing official and take other action as required by this section to carry out the designated reviewing official's determination.

4. Non-Reviewable Grounds for Denial of Access to PHI. LifeWays may deny an individual access without providing the individual an opportunity for review, in the following circumstances:
   a. The request for psychotherapy notes;
   b. Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
   c. An inmate's request to obtain a copy of PHI, if obtaining such copy would:
      (i) jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates; or
      (ii) jeopardize the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate;
   d. Protected health information contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law; or
   e. The protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

5. Reviewable Grounds for Denial. LifeWays may deny an individual access, provided that the individual is given a right to have such denials reviewed, in the following circumstances:
   a. A licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person;
   b. The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
   c. The request for access is made by the individual's legally authorized representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such representative is reasonably likely to cause substantial harm to the individual or another person.

| CHAPTER | | GOVERNING POLICY | |
|---|---|---|---|
| 6.00 Customer Services | | 03. Medical Record Management | |
| **SUBJECT:** | | | |
| 02 Consumer Access to Medical Records | | | |
| **EFFECTIVE DATE**: | 12/01/2013 | **REVIEWED/REVISED:** | 11/01/2014 |

If access is denied by one of these grounds, the individual has the right to have the denial reviewed by a licensed health care professional who is designated by LifeWays to act as a reviewing official and who did not participate in the original decision to deny.

6. Documentation. All release requests and completed releases shall be documented within LEO through the "Document Disclosure" log.
   a. Date released
   b. Scanned Application
   c. Brief description of what was actually released to the individual
   d. Purpose for the release
   e. Information regarding the denial of access.
   f. LifeWays Personnel facilitating the release

7. In accordance with the Medical Records Access Act 47 of 2004 (333.26269 Section 9), LifeWays has established the following fee structure for complying with requests. LifeWays staff may use discretion when applying costs. The individuals shall be made aware of costs prior to duplication.
   - Paper copies:
     - Initial fee of $20.00 per request for a copy of the record
     - One dollar per page for the first 20 pages
     - Fifty cents per page for pages 21 through 50
     - Twenty cents for pages 51 and over
   - For digital duplication onto a password protected encrypted flash drive: $35.00.
   - Postage or shipping costs
   - Actual costs incurred for records older than seven years.

| **REFERENCES** |
|---|
| 45 CFR 164.524<br>Attachments<br>Application for Access to Recipient Case Record Information – LW#60302-A<br>Request for Access to Medical Records Notice of Denial – LW#60302-B |
| **HISTORY** |
| Effective 12/01/2013 \| Rev. |

LifeWays
Community Mental Health
www.lifewayscmh.org

# APPLICATION FOR ACCESS TO RECIPIENT CASE RECORD INFORMATION

I, _____ , hereby request access to information from the case record of

_____ _____ and/or _____.
(Name of Recipient) (Date of Birth) (Social Security Number)

My relationship to the recipient is (check one): ____ Recipient ____ Parent ____ Guardian

_____ _____
Address Telephone #

Documentation of the relationship to the recipient and personal information may be required prior to disclosure of the information requested.

____ I am requesting an appointment to review any/all information in the case record. I understand and accept that the supervisor and/or his/her designee will be present when I am reviewing the materials in the record. I understand and accept that I may not remove, change or destroy any materials in the record. I may submit additional information for the record, which may correct information contained in the case record or which may express views that differ from those expressed in materials contained in the case record.

____ I am requesting to receive a copy of any/all information in the case record. Specific information requested, if any, is:

_____

_____

_____

I would like to receive this information in ____ Paper Form ____ Encrypted/Password Protected Flash Drive

I understand and accept there may be a charge for the cost of materials for receiving the information requested. I will be informed of the amount prior to processing.

I understand and accept that the Agency is the holder of the record and may, under the authority of State law, withhold information, which it determines to be detrimental to the recipient or to other persons. (Michigan Mental Health Code Section 330/1748 (5)(b).

I understand that upon possession, I take full responsibility for the protection and confidentiality of the information provided.

_____ _____
Date Signature

This page is to be completed by supervisor:

_____ I have verified that the above listed individual is authorized to receive the information requested above. An appointment has been scheduled for review/release on _____ .
(Date)

_____ I have reviewed the information requested above and have recommend the following information not be disclosed:

_____

_____

_____

For the following reason:

Non-Reviewable

___ The request is for psychotherapy notes;
___ Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
___ An inmate's request to obtain a copy of PHI, if obtaining such copy would:
(i) jeopardize the health, safety, security, custody, or rehabilitation of the individual or of other inmates; or
(ii) jeopardize the safety of any officer, employee, or other person at the correctional institution or responsible for the transporting of the inmate;
___ Protected health information contained in records that are subject to the Privacy Act, 5 U.S.C. 552a, may be denied, if the denial of access under the Privacy Act would meet the requirements of that law; or
___ The protected health information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

Reviewable

___ A licensed health care professional has determined, in the exercise of professional judgment, that the access is reasonably likely to endanger the life or physical safety of the individual or another person;
___ The PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
___The request for access is made by the individual's legally authorized representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such representative is reasonably likely to cause substantial harm to the individual or another person.

____ **Written denial has been provided to the requestor.**

_____ _____
Date Authorized Personnel Signature

Copy to: Administrative File, Recipient's File, Recipient or Parent/Guardian.

LifeWays
Community Mental Health

**REQUEST FOR ACCESS TO MEDICAL RECORDS – NOTICE OF DENIAL**

August 3, 2015

**Patient Name:**
**Guardian Name (If applicable):**
**Address:**

**Phone No.:**
**Record No.:**
**Date of Birth:**
**Date of Service:**

**Relationship to Patient** (Check one)

_____ Patient _____Parent _____Legally Authorized Representative

Dear _____:

This letter is in response to your request dated _____ to access your health information, which we received from you on _____. This request has been reviewed by a licensed health care professional. The health information is enclosed with this correspondence, however, a portion of your request has been denied.

Under federal law, we are not required to provide the information in the event a licensed health care professional has determined, in the exercise of professional judgment, that the access is _____language taken from page 2 of Application for Access to Recipient Case Record Information_____. This denial applies to a portion of the information you requested. The portion of your request denied is the _____.

**[Determine which paragraph is needed depending on the reason for denial]** You have the right to have this decision reviewed by licensed health care professionals not directly involved in our initial decision to deny your request. If you want to exercise this right, please contact the LifeWays Customer Service Department at 866-630-3690. We will comply with the health care professionals' decision.

**[Determine which paragraph is needed depending on the reason for denial]**Due to the reason cited for denial, the federal law does not allow the right to have this decision reviewed.

If you believe we have improperly handled your request to access your protected health information, you may file a complaint with us or with the Secretary of the United States Department of Health and Human Services. To file a complaint with us, please contact the LifeWays Customer Service Department at 866-630-3690. Please be assured, no one will retaliate or take action against you for filing a complaint.

Thank you,

Elizabeth Knoblauch
Director of Strategic Relations

| **SECTION** | | **GOVERNING POLICY** | |
|---|---|---|---|
| 7.00 Information Systems (IS) | | 02. IS Security and Risk Management | |
| **SUBJECT:** | | | |
| 01 Business Continuity and Disaster Recovery | | | |
| **EFFECTIVE DATE**: | 08/21/2002 | **REVIEWED/REVISED:** | 03/01/2014 |

**07-02.01 BUSINESS CONTINUITY AND DISASTER RECOVERY**

PURPOSE: Each division within the agency is responsible for creating, maintaining and testing its business continuity and disaster recovery plans in order to effectively resume operations during a disaster or service disruption. The Information Technology (IT) Team is responsible to provide successful contingency plans in the event that the agency's information system infrastructure is compromised. The contingency plan shall include technical capabilities designed to support contingency operations. The procedure includes best practices to mitigate the agency's risk of disruption to the continuity of business operations and shall be maintained, tested and evaluated periodically.

INFORMATION TECHNOLOGY DEPARTMENT RESPONSIBILITIES

The IT (Information Technology) Department is responsible to maintain a detailed IT Disaster Recovery Plan that identifies responsibilities of key personnel, response procedure, methods to evaluate effectiveness of response, and recommendations for contingency operations until business is restored.

The IT Department will work with the Disaster Management Coordination, a designee of the CEO, to implement contingency plans and works towards systems restore.

BEST PRACTICES TO MITIGATE DATA LOSS AND SYSTEMS COMPROMISE

The IT Department will implement the following practices to mitigate data loss when the IT systems have been compromised:

1) <u>System Security</u>:

Currently LifeWays' systems require valid login and passwords at all levels of access. From a desktop a user must provider authentication to the network. The user is then required to enter a password to use specific applications. Some applications are limited by user license. In the electronic medical record, the user is required to have a need-to-know and access level is managed by a systems administrator. Other security policies employed:

- Network passwords are required to be a "strong" password (includes letters, number, upper case and lower case characters) and are set to automatically expire every 90 days;
- Passwords must contain a minimum of 5 characters;
- Old passwords can only be reused after a minimum of 3 expiration cycles;
- Users are "locked out" after 4 unsuccessful attempts, and IT Help Desk must clear locks; and
- Access to shared resources is granted on a needs basis, determined by IT Director and Chief Executive Officer.

| SECTION | | GOVERNING POLICY | |
|---|---|---|---|
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| **EFFECTIVE DATE**: | 08/21/2002 | **REVIEWED/REVISED:** | 03/01/2014 |

2) Power Management:

The local area network (LAN) in the Jackson LifeWays office gets its power from a series of uninterrupted power supply (UPS), which is powered from power supplied by Consumers Energy. In the event of a power loss, the UPS will keep the servers alive for up to 20 minutes, allowing time for orderly shutdown of the systems. Only the computers in the server room are powered from the UPS; all client computers will be immediately affected in the case of a general loss of power from Consumers Energy.

The telephone system is connected directly to a UPS device in the Main Distribution Facility (MDF) and in each intermediate distribution frame (IDF). The UPS devices will automatically deliver power to the phone system for a period of approximately 20 minutes, after which the phone system will shut down if power has not been restored

3) Backup & Restore:

LifeWays currently backs up its mission critical systems on a daily basis.

- Backup drives are kept offsite.
- All data, operating systems and utility files must be adequately and systematically backed up (including all patches, fixes and updates).
- Records of what is backed up and to where must be maintained.
- Records of software licensing is backed up.
- The backup media must be precisely labeled and accurate records must be maintained of back-ups done and to which back-up set they belong.
- Copies of the backup media, together with the backup record, should be stored safely in a remote location, at a sufficient distance away to escape any damage from a disaster that may occur at the main site.
- Regular tests of restoring data/software from the backup copies should be performed, to ensure reliability in the event of an emergency.
- All LifeWays systems which are owned and operated by LifeWays and which are housed in the Server room are backed-up daily.

Incremental backups are performed Sunday through Friday at 10:00 p.m. and take approximately 2 hours. Full backups are performed on Saturdays at 10:00 p.m. and take approximately 8 hours. Different backup schedules can be set up for particular machines by arrangement, but IT staff would not normally run backups during "prime shift" hours, i.e. between 8:00 a.m. and 6:00 p.m. on weekdays. The Shadow Copy Service is also used, which takes a snapshot of the data at 7:00 a.m., 12:30 p.m., and 6:00 p.m. daily. This provides the ability to restore a file immediately without having to use backup media.

Files can only be restored to the state they were in at the time the most recent relevant backup\shadow copy was taken (though users may request restores from earlier backups if they wish).

| **SECTION** | | **GOVERNING POLICY** | |
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4) Telephone Management:

Currently at LifeWays there is one phone system in use. The system is a Cisco Unified Communications System running on two Cisco Call Managers. In the event that Call Manager 1 goes down, Call Manager 2 has the ability to continue carrying out the last programming functions given to it by Call Manager 1. The system will not be fully functional until Call Manager 1 is back online. Call Manager 2 ensures that critical services such as dial tone and the ability to make and receive calls remain up. The two systems are connected in a virtual server environment. Voice mail is provided to the system through a Cisco Unity Connection Voice Mail Server. LifeWays staff maintains these systems with support through a contract with NuWave Technology Partners.

When either system fails, LifeWays IT staff will evaluate the failure and either make repairs or contact NuWave Technology Partners using the following:

Call: 877-342-4401

Use as much detail as available to explain the problem.

Typically when a problem develops with the actual telephones lines another call may be needed to the phone company for repairs.

Should there be a complete failure of lines, or other catastrophic event (extended power outage), contact NuWave Technology Partners at the above number to have the lines forwarded offsite as per Attachment A for the Telephone System.

LifeWays currently utilizes a 10 megabits per second IP Flex circuit to carry its phone and data traffic. This circuit is provided by AT&T at the Jackson location. These lines are answered by the phone system and all incoming calls are then distributed to the desktop telephones. All outgoing calls also utilize the same circuit that has the capacity to support multiple calls. All calls delivered by the circuit are handled by the Call Managers and routed to the appropriate phone extension or call group.

All calls come in and out of the network on the PRIs. The PRI (Primary Rate Interface) is circuits are labeled as follows:

=> This is a Single Unlimited local PRI
=> This is 2 unlimited local PRIs

The following is a list of Phone # Direct Inward Dialing (DID) that are associated with the above PRIs:

| | |
|---|---|
| LW Jackson DID Range(s) | 517.789.1200-1239<br>517.789.1260-1299<br>517.789.2480-2499<br>517.780.3300-3399<br>517.796.4500-4599 |

| **SECTION** | | **GOVERNING POLICY** | |
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| **EFFECTIVE DATE**: | 08/21/2002 | **REVIEWED/REVISED:** | 03/01/2014 |

PROCEDURE FOR FORWARDING TELEPHONES

In the event there is an evacuation order for 1200 N West Avenue, the following should be done to forward LifeWays' telephones to a backup location

Currently, the only number that is set up for forwarding to an Alternate Location is the Crisis Line. To forward the Crisis Line to our after hours site (Gryphon Place) perform the following task.

Call the AT&T CLAR phone number at 517-483-9994
When prompted, enter the following pin: 99999999
When prompted, enter the following plan: 1111#

At the end of the crisis when the evacuation order has been lifted and the building at 1200 N West can again be occupied, follow these steps to "un forward" the telephone lines:

Call the AT&T CLAR phone number at 517-483-9994
When prompted, enter the following pin: 99999999
When prompted, enter the following plan: 0#

EVALUATION OF RESPONSE

After the system has been restored, the IT Department shall participate in a review of the effectiveness of its response and the ability to restore the information system infrastructure to original status. This evaluation will include recommendations for improvement, which will be reported to the Chief Executive Officer and Disaster Recovery Coordinator.

| **REFERENCES** | |
|---|---|
| LifeWays' Enterprise Risk Management & Disaster Response Plan<br>LifeWays Operating Procedures<br>7-02.02 Information Access and Systems Security<br>7-02.03 Data Backup and Restore<br>7-02.04 Data Archival, Retention and Disposal | |
| **HISTORY** | |
| Formerly LifeWays Operating Procedure 07-03.01 Disaster Management Plan | |
| Effective 08/21/2002 | Rev. 10/03, 07/05, 08/09 |